Minnesota Board of Marriage and Family Therapy
2829 University Avenue SE, Suite 400
Minneapolis, MN 55414-3222
Telephone: (612) 617-2220 Fax: (612) 617-2221
Email: mft.board@state.mn.us Website: www.bmft.state.mn.us
Hearing Impaired-Minnesota Relay Service: 1-800-627-3529

APPLICATION FOR MARRIAGE AND FAMILY THERAPIST LICENSURE (LMFT) BY STATE EXAMINATION

Instructions:

1. Application is ten (10) pages. Please check to insure a complete application is submitted to the Board.

2. Type all answers or print in black ink. Complete all sections. If a section is not applicable, enter N/A in the space provided.

3. If additional response information is required for any question, please attach a separate sheet of paper. Identify the question to which the answer applies and include **your printed name and signature on each page**.

4. Affirmation of Applicant (page 6) requires **signature notarization**. **Original** signatures are required on this form.

5. Review instructions on page 9 for completing Post-Graduate Experience and Supervision Verification Form (page 10). **Original** signatures are required on the verification form(s).

6. Two endorsements are required for application (pages 7 and 8). A Board-approved supervisor may also serve as an endorser. **Original** signatures are required on the endorsement form.

7. Attach a check payable to "**MN Board of MFT**" for the application fee of **$110.00**. All fees are nonrefundable.

8. Mail this application to: MN Board of MFT, 2829 University Ave SE, Suite 400, Minneapolis, MN 55414. Keep a copy of all documents submitted to the Board.

9. If your application for licensure is approved, you will be notified electronically, and the LMFT state licensure (oral) examination with the Board will be scheduled within 60 days of notification of application approval. Upon successful completion of the state licensure examination, you will be required to remit the annual LMFT licensing fee of $125.00, which will be prorated, dependent upon the month in which your LMFT license is issued.

This document is available in alternative formats to individuals with disabilities by calling (612) 617-2220, or, through the Minnesota Relay Service at (800) 627-3529.

Office Use Only: Check#:_____ Amount: $_____ Deposit #:_____

Rights of Subject of Data: Information you provide as an applicant, except for your name and address, is classified as private while you remain an applicant; that is, accessible only to you, the staff and members of the Board, the Board's counsel, and persons you designate. When you become licensed, the information in your file related to your licensure is classified as public. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. You are not legally required to provide this information, but you cannot be licensed without doing so.

Tax Clearance Information (Minn. Stat. 270C.72): The Board is required to provide to the MN Department of Revenue your social security number. Upon request of the Commissioner of Revenue, the Board must provide to the Commissioner a list of all regulated individuals and applicants, including their names and addresses, social security numbers, and business identifications numbers. (1) This information may be used to deny the issuance or renewal of your license in the event you owe the Minnesota Department of Revenue delinquent taxes in the amount of $500.00 or more. (2) Upon receiving this information, the Board will supply it only to the Minnesota Department of Revenue. However, under the Federal Exchange of Information Agreement, the Department of Revenue may supply this information to the Internal Revenue Service. (3) Failure to supply this information may prevent or delay the processing of your application.

Tennessen Warning (Minn. Stat. 13.04): Data collected under "Ethical Qualifications" is confidential/non-public and may be used for investigative purposes. The Board is seeking data from you which may be considered private or confidential under the Minnesota Government Data Practices Act, Minn. Stat. 13.01 et seq. Minn. Stat. 13.04, subd. 2 requires the Board to notify you of the following four matters before you are asked to supply such information about yourself: (1) This data is being collected to determine whether you meet the requirements for licensure as well as whether you have violated any statutes or rules the Board is empowered to enforce; (2) You are not legally required to complete and return this application, but failure to do so may result in the denial of this application; (3) If you supply the data requested and it shows a violation of any of the statutes or rules enforced by the Board, you may be subject to disciplinary or other action by the Board. If you refuse to supply the data requested, your application may be denied. In addition, falsification or omission of information may be used by the Board as a basis for disciplinary action; and (4) The data which you supply will be accessible to Board staff. The data you supply may also be released to other persons and/or governmental entities that have statutory authority to review the data, investigate specific conduct, and/or take appropriate legal action. If the Board institutes a formal disciplinary action against you, the information you supply could become public.

APPLICATION FOR LICENSED MARRIAGE AND FAMILY THERAPIST (LMFT) BY STATE EXAMINATION

Applicant Information

NAME: Last	First	Middle
LAST 4 DIGITS OF SOCIAL SECURITY #: ____ ____ ____ ____	**DATE OF BIRTH:**	
PUBLIC ADDRESS: (Street Address)	(City) (State)	(Zip Code)
MAILING ADDRESS: (Street Address) If same as public address, check here ☐	(City) (State)	(Zip Code)
***PRIMARY BUSINESS OR AGENCY NAME:**		
BUSINESS ADDRESS: (Street Address)	(City) (State)	(Zip Code)
EMAIL (please print clearly/for Board notification use only):		
TELEPHONE: (At least one number is required.) Business: Home: Cell:		
Designated phone number for release to Public: ☐ **Business** ☐ **Home** ☐ **Cell**		

***Important:** Applicants must provide a primary business address at time of initial application and all subsequent license renewals. Your primary business address is public. If you are not currently in the workforce related to mental health practice, write "Not Working" in the primary business address section above. *See* Minn. Stat. 214.073**.**

Office Use Only: Check#:_____ Amount: $_____ Deposit #:_____

Ethical Qualifications

FOR QUESTIONS 1 THROUGH 11, YOU MUST REPORT INCIDENCES/OFFENSES THAT YOU HAVE NOT PREVIOUSLY REPORTED ON ANY PRIOR APPLICATION OR LAMFT LICENSE RENEWAL FILED WITH THIS BOARD.

If you answer "Yes" to any question, you **must include** a signed, written explanation and provide any relevant documents. Answering "Yes" to certain questions may require special screening or review procedures by the Board. Failure to disclose requested information or a false answer to any question may result in denial of your application or other Board action.

Y ___ N ___	1. Have you been convicted, pled guilty or pled no contest to a misdemeanor, gross misdemeanor or felony, or have criminal charges been filed against you? Include traffic offenses where the charge involves the use of alcohol or drugs even if the final conviction or plea is not related to the use of alcohol or drugs.
Y ___ N ___	2. Have you been found to be in violation of a professional association's code of ethics, or of a state licensing board's rules, regulations or statutes regarding professional conduct?
Y ___ N ___	3. Have you been investigated, sanctioned or disciplined by a professional association or state licensing board?
Y ___ N ___	4. Do you hold or have you ever held a license, certificate or registration to practice marriage and family therapy or any other health-related profession in MN or any other jurisdiction which has been revoked, suspended or otherwise had action taken against it for any reason?
Y ___ N ___	5. Have you voluntarily surrendered any professional license or registration issued by a professional association or state licensing board, or allowed a license or professional registration to lapse, while a complaint was pending against you with the professional association or state licensing board?
Y ___ N ___	6. Have you had an application denied, or been denied membership or licensure by any professional association or state licensing board?
Y ___ N ___	7. Have you been subjected to disciplinary action by a post-secondary educational institution, withdrawn from a post-secondary educational institution or been investigated by a post-secondary educational institution, because of alleged misconduct of any kind?
Y ___ N ___	8. Have you been named as a party to civil litigation, arbitration, mediation or a malpractice action related in any way to your profession?
Y ___ N ___	9. Are you currently unable to practice with reasonable skill and safety by reason of illness, use of alcohol, drugs, chemicals or any other materials, or as a result of any mental, physical or psychological condition?
Y ___ N ___	10. Do you participate in any program, other than the State of Minnesota's Health Professional Services Program (HPSP), designed to monitor or assist you in the management of a chemical dependency, physical, psychological or emotional impairment?
Y ___ N ___	11. Do you currently have any other condition or impairment, not reported in any question in this application, which in any way affects, or if left untreated might affect, your ability to practice marriage and family therapy with reasonable skill and safety to clients?

POST-GRADUATE EXPERIENCE AND SUPERVISION SUMMARY

To Be Completed by the APPLICANT

Applicant Name: Last	First	Middle	Suffix

Instructions

- On this page, the applicant will summarize all client contact and supervision hours reported on the Verification form (page 10) completed by the applicant's Board-approved LMFT supervisor(s).
- Complete the table using the information reported by your LMFT Board-approved upervisor(s) on the Verification form (page 10).
- If you have more than 5 supervisors, please attach a separate sheet of paper and provide the required information for each additional supervisor. Include **your printed name on each attached page.**
- Verify that the information you report in the table below matches exactly with the hours reported by your supervisor(s) on the Verification form (page 10).
- Verify that your reported hours meet the required minimum for LMFT licensure.

CLIENT CONTACT AND SUPERVISION HOUR SUMMARY

A. Board-approved Supervisor Name/License Credential	B. Start/End Dates of Supervision	C. Couple/Family Client Contact Hours	D. All Other Client Contact Hours	E. Individual Supervision Hours (face-to-face and electronic)	F. Group Supervision Hours (face-to-face and electronic)
Ex. John Doe, LMFT	*1/1/2014 – 8/1/2014*	*44*	*35*	*10*	*5*
TOTALS:					
		Column C must equal or exceed 500 hours.	**Columns C + D must equal or exceed 1000 hours.**	**Column E must equal or exceed 100 hours.**	**Column E + F must equal or exceed 200 hours.**

Affirmation of Applicant

Attention: Please read the following paragraphs carefully before signing this application:

STATE OF (where notarized) _____)

COUNTY OF (where notarized) _____)

I, _____ *(print name of applicant),* **hereby apply for the LMFT license, under the laws and regulations governing marriage and family therapy licensure, and certify under penalty of perjury that all statements contained herein are true and correct to the best of my knowledge and belief; and that I am the person named in the application submitted, and that I completed the clinical client contact and supervision hours reported herein, without fraud or misrepresentation; with full knowledge that all statements made in this application may be subject to investigation; and that any false or dishonest answers to any questions in the application may be grounds for refusal, or subsequent revocation or suspension, of my license.**

I hereby acknowledge I have reviewed Minnesota Statutes, Sections 148B.01 to 148B.1751 and 148B.29 to 148B.39, and administrative rules promulgated by the Board of Marriage and Family Therapy. I understand that I am under a continuing obligation to keep informed of any changes to the law and rules governing marriage and family therapy licensure.

I hereby affirm that I have read the Code of Ethics adopted by the State of Minnesota Board of Marriage and Family Therapy. I agree to conduct all professional activities as a licensed marriage and family therapist in accordance with the Code of Ethics adopted by the Board.

_____
Signature of Applicant

Subscribed and sworn to before me this _____ day of _____ 20_____

_____
Signature of Notary Public

My commission expires: _____ Notary Seal

Applicant Endorsement #1

Application for Licensed Marriage and Family Therapist (LMFT License)

APPLICANT NAME: _____

Last First MI

To Be Completed By Endorser: Type or print all answers in black ink. Complete all sections on this page.

Endorser Name: _____

Last First MI

Contact Email address: _____

Contact Telephone Number: _____

Qualifications of Endorser (Endorser must be a Licensed Marriage and Family Therapist)

1. Are you an employee, client or former client of the applicant, or related to the applicant in any way?
   _____ Yes _____ No

2. Are you licensed by the Minnesota Board of Marriage and Family Therapy? _____ Yes _____ No
   If yes, MN LMFT license number: _____ If no, go to question #3.

3. If you answered "No" to question #2, are you licensed as a Marriage and Family Therapist in another state whose licensure requirements are equivalent to Minnesota LMFT licensure requirements?
   _____ Yes _____No If yes, License # and State where issued:_____
   If no, you may not serve as an endorser.

Endorsement of Applicant

4. Do you believe that the applicant for LMFT licensure is qualified to practice independently?
   _____ Yes _____ No If no, please explain.

5. To the best of your knowledge, has the applicant for LMFT licensure violated any statute, rule or ethical standard governing the practice of marriage and family therapy?
   _____Yes _____ No If yes, please explain.

I hereby attest to the above-named applicant's professional and ethical character.

_____ _____

Signature of Endorser Date

After completion, Endorser may return form to applicant for inclusion with Application for LMFT Licensure or mail form directly to: **MN Board of MFT**, 2829 University Ave. SE, Suite 400, Minneapolis, MN 55414. Please notify applicant if submitting form directly to MN Board of MFT.

Applicant Endorsement #2

Application for Licensed Marriage and Family Therapist (LMFT License)

APPLICANT NAME: _____

Last First MI

To Be Completed By Endorser: Type or print all answers in black ink. Complete all sections on this page.

Endorser Name: _____

Last First MI

Contact Email address: _____

Contact Telephone Number: _____

Qualifications of Endorser (Endorser must be a Licensed Marriage and Family Therapist)

1. Are you an employee, client, or former client of the applicant, or related to the applicant in any way?
   _____ Yes _____ No

2. Are you licensed by the Minnesota Board of Marriage and Family Therapy? _____ Yes _____ No
   If yes, MN LMFT license number: _____ If no, go to question #3.

3. If you answered "No" to question #2, are you licensed as a Marriage and Family Therapist in another state whose licensure requirements are equivalent to Minnesota LMFT licensure requirements?
   _____ Yes _____No If yes, License # and State where issued:_____
   If no, you may not serve as an endorser.

Endorsement of Applicant

4. Do you believe that the applicant for LMFT licensure is qualified to practice independently?
   _____ Yes _____ No If no, please explain.

5. To the best of your knowledge, has the applicant for LMFT licensure violated any statute, rule or ethical standard governing the practice of marriage and family therapy?
   _____Yes _____ No If yes, please explain.

I hereby attest to the above-named applicant's professional and ethical character.

_____ _____

Signature of Endorser Date

After completion, Endorser may return form to applicant for inclusion with Application for LMFT Licensure or mail form directly to: **MN Board of MFT**, 2829 University Ave. SE, Suite 400, Minneapolis, MN 55414. Please notify applicant if submitting form directly to MN Board of MFT.

POST-GRADUATE EXPERIENCE AND SUPERVISION VERIFICATION FORM

Application for Licensed Marriage and Family Therapist (LMFT) by State Examination

Instructions / Checklist

- Make copies as needed and submit ONE form for EACH LMFT Board-approved supervisor.
- All fields must be completed. The applicant is strongly encouraged to meet with the Board-approved supervisor when completing the form. Reported hours must be verified with the supervisor to avoid incorrect filing of hours with the Board.
- Original signatures are required. Copies will not be accepted.
- The supervisor MUST initial ANY corrections to the form(s), including white-outs and crossed out information.
- Signatures cannot be dated or form completed prior to the last date of experience/supervision.
- The supervisor must be a MN Board-approved LMFT Supervisor at time of supervision or, if client contact and supervision took place in another jurisdiction, an LMFT authorized to provide supervision for purposes of licensure in that other jurisdiction.
- Experience and supervision hours must be completed after the date on which the applicant's qualifying MFT graduate degree was awarded (the date recorded on transcript).
- Client contact hours logged while under the supervision of one or more Board-approved LMFT supervisors **must be** divided amongst the appropriate supervisors so as to avoid over-reporting and/or double-counting of client contact hours. If division of hours is not possible, applicant **must attach** written explanation of same hours reported under more than one Board-approved LMFT supervisor.
- Submit all Post-Graduate Verification Form(s) together to the Board as part of your Application for LMFT Licensure

Experience:

- Qualifying experience is defined in Minnesota Rule 5300.0150 or Minnesota Rule 5300.0155.
- All Verification Forms, together, must document a total of *at least* 1,000 hours of direct client contact over a **minimum** of 24 months, at least 500 of which must be hours with couples and families.

Supervision:

- Supervision for purposes of licensure is defined in Minnesota Rule 5300.0150 or Minnesota Rule 5300.0155.
- All Verification Forms, together, must document a total of *at least* 200 hours of supervision over a **minimum** of 24 months, at least 100 of which must be individual supervision. No more than 50 hours of synchronous electronic supervision may be reported.

POST-GRADUATE EXPERIENCE AND SUPERVISION VERIFICATION FORM

SECTION 1: To be completed by the APPLICANT

Applicant Name: Last	First:	Middle:	Suffix
Place of Employment/Site of Clinical Experience:			

SECTION 2: To be completed by the CLINICAL SUPERVISOR

The information listed below must reflect only those post-graduate activities and services the applicant performed under supervision by a MN Board-approved LMFT supervisor or, if client contact and supervision occurred in another jurisdiction, an LMFT authorized to provide supervision for purposes of licensure in that other jurisdiction. Experience and supervision must be done concurrently.

EXPERIENCE and SUPERVISION was conducted and completed between_____ and _____as follows:
(mm/dd/yyyy) (mm/dd/yyyy)

EXPERIENCE **Post-Graduate**: 1,000 client contact hours, with at least 500 hours with couples/families, over a minimum of 24 months	**SUPERVISION** **Post-Graduate**: 200 clock hours, with at least 100 hours of individual supervision, over a minimum of 24 months
(a)_____hours of **face-to-face clinical client contact** with **couples and families** for the purpose of diagnosis, assessment, and treatment (b)_____hours of **face-to-face clinical client contact** other than with couples and families (individual or other) for the purpose of diagnosis, assessment and treatment _____**TOTAL HOURS** of post-graduate client contact *All supervision forms submitted with application, added together, must equal at least 500 hours of direct client contact with couples and families and total direct client contact hours of at least 1,000 hours.*	(a)_____hours of **face-to-face individual** supervision providing assessment and evaluation of applicant's clinical work (no more than two supervisees present) (b)_____hours of **electronic individual** supervision (no more than two supervisees present) (c)_____hours of **face-to-face group** supervision providing assessment and evaluation of applicant's clinical work (no more than six supervises present) (d)_____hours of **electronic group** supervision (no more than six supervises present) _____**TOTAL HOURS** of post-graduate supervision *All supervision forms submitted with application, added together, must equal at least 100 hours of individual supervision and total supervision of at least 200 hours. No more than 50 hours of synchronous electronic supervision may be reported.*

Supervisor Name (print)**:**				
Contact Telephone:		**Contact Email:**		
State where experience/ supervision took place	**License Credential**	**License Number**	**License Issue Date** (mm/dd/yyyy)	**Expiration Date** (mm/dd/yyyy)

I DECLARE that the statements made on this verification are true and complete to the best of my knowledge, that the applicant completed the post-graduate supervised experience and supervision hours documented on this form, and that I am aware of no fact or circumstance that would disqualify this applicant from seeking LMFT licensure.

Supervisor Signature:_____